APPLICATION/APPOINTMENT OF TEMPORARY CONSERVATOR
PC-302 (BBS) REV. 10/05

STATE OF CONNECTICUT
COURT OF PROBATE
[***Type or print in black ink.***]

RECORDED:

TO: COURT OF PROBATE, DISTRICT OF **DISTRICT NO.**

IN THE MATTER OF

RESPONDENT'S SOCIAL SECURITY NUMBER [***if available***]

RESPONDENT'S DATE OF BIRTH

Hereinafter referred to as the respondent, a proceeding for involuntary representation.

DOMICILE OF RESPONDENT [***Complete address***]

PRESENT ADDRESS OF RESPONDENT [***If institutionalized, give name and address of institution.***]

PETITIONER [***Name, address, zip code, and telephone number***]

RELATIONSHIP OF PETITIONER TO RESPONDENT [***C.G.S. §45a-654***]

PERSONS TO WHOM NOTICE SHOULD BE GIVEN: SPOUSE [***If not the petitioner***], CLOSEST RELATIVES [***If none, so state***], and INTERESTED PARTIES as defined in ***Probate Practice Book***, Rule 3.1.02.[***Give names, addresses, zip codes, and relationships to respondent.***(C.G.S. §45a-649).]

Additional data [***on Second Sheet, PC-180***], if any, is made a part hereof.

THE PETITIONER REPRESENTS that the respondent is:

☐ incapable of managing his/her affairs and has personal property with an estimated value of $ and real property with an estimated value of $

☐ incapable of caring for himself/herself AND

- ☐ ***has*** ☐ ***has not*** designated a conservator as provided by C.G.S. §§45a-645, 45a-650.
- ☐ ***has*** ☐ ***has not*** executed a living will.
- ☐ ***has*** ☐ ***has not*** appointed a health care agent.[***Include name and address. If unknown, so state.***]
- ☐ ***has*** ☐ ***has not*** executed a power of attorney for health care decisions. [***Include name and address of person appointed to act. If unknown, so state.***]
- ☐ ***is*** ☐ ***is not*** able to request or obtain an attorney. [C.G.S. §45a-649.]
- ☐ ***is*** ☐ ***is not*** able to pay for the services of an attorney. [***Submit affidavit of financial status.*** (C.G.S. §45a-649).]
- ☐ ***is or is expected to become*** an inpatient or outpatient in a hospital, clinic, or other facility for the diagnosis, observation, or treatment of mental illness. [***Note: If this box is checked, AND if consent or other authorization is being sought for (a) psychiatric medication treatment and/or (b) shock therapy, special statutory requirements must be met. The applicable forms (CM-42 or CM-46 for psychiatric medication and CM-44 for shock therapy), together with all supporting documentation, MUST be attached to this form. ALL of the documents filed in connection therewith will be recorded in a confidential volume.***]

[Note:If Commissioner of Social Services is proposed conservator of estate and/or person, attach Affidavit, PC-310, C.G.S. §45a-651.]

Immediate and irreparable injury to the mental or physical health or financial or legal affairs of the respondent will result if a temporary conservator is not appointed. [***Briefly describe reasons. Use Second Sheet, PC-180, if additional space is needed.***]

☐ The Report signed by a Connecticut-licensed physician who has examined the respondent is attached hereto and made part of this application. [C.G.S. §45a-654(b)(1).]

THE PETITIONER FURTHER REPRESENTS that the contents of this application are true to the petitioner's best knowledge and belief and requests that this Court appoint the proposed temporary:

☐ Conservator of the Person.

☐ Conservator of the Estate.

The representations contained herein are made under the penalties of false statement.

Date: .....

Petitioner:

PROPOSED TEMPORARY CONSERVATOR(S)

If appointed, I/we will accept said position(s) of trust, as temporary conservator(s) of the:

Person [***Complete this section.***] Estate [***Complete this section.***]

Signature..... .....

Name [***Type or print***]

Address

Telephone number:

ATTORNEY FOR THE PETITIONER [***Name, address, zip code, telephone number, and juris number.***]

ATTORNEY FOR THE RESPONDENT [***Name, address, zip code, telephone number, and juris number.***]